TUFTS MEDICARE COMPLEMENT MEMBER ENROLLMENT FORM

TUFTS Health Plan

Please print or type. Please be sure application is completed in full to ensure enrollment. **Enrollment/Eligibility • PO Box 9186 • Watertown, Massachusetts 02471-9186**

Employer Section

FAILURE TO COMPLETE AREAS MARKED IN BLUE MAY CAUSE A DELAY IN ENROLLMENT.

1. Name of Employer or Group	2. Group Number	3. Effective Date of Coverage

Member Section

4. Subscriber's Medicare #_____

5. Have you or anyone in your family used tobacco products e.g., cigarettes, chewing tobacco, etc. in the last 12 months? ❑ Yes ❑ No

6. Last Name	7. First Name	8. Middle Initial
9. Member's Social Security Number (SSN)	10. Date of Birth (MM/DD/YYYY) / /	11. Gender ❑ M ❑ F
12. Mailing Address (Home address)		13. Apt#
14. City	15. State	16. ZIP
17. Primary Care Provider	18. PCP ID#	19. Check if currently used for primary care ❑
20. Home Telephone ( )	21. Fitness Center	22. Primary Language

IMPORTANT: TO ENROLL, PLEASE ATTACH A COPY OF YOUR MEDICARE CARD.

23. Do you currently have Tufts Health Plan through a group plan? ❑ Yes ❑ No If yes, what is your membership number?_____

24. Are you or your spouse actively working for the sponsoring employer? ❑ Yes ❑ No (YOU) ❑ Yes ❑ No (SPOUSE)

25. Has end stage renal disease qualified you for Medicare parts A & B? ❑ Yes ❑ No If yes, please indicate your certification dates:
Part A _____ / _____ / _____ Part B _____ / _____ / _____

26. Do you have other health care coverage (including Medicare)? ❑ Yes ❑ No If yes, please indicate the plan: _____

The information supplied on this form is true and complete. I acknowledge that I must continue to be enrolled in Medicare Parts A & B or I will be ineligible forTufts Medicare Complement coverage effective as of the date I discontinue either Medicare Part A or B. I authorize my employer (sponsor) to remit my share of Tufts Medicare Complement (TMC) premium together with any contributions by my employer (sponsor). I assign benefits to Tufts Health Plan providers, which means that Tufts Health Plan is authorized to make payments directly to Tufts Health Plan providers for services rendered to me. I grant Tufts Health Plan any legal right that I may have to recover the cost of services for an illness or injury caused by someone else when these services have been or will be paid for by Tufts Health Plan. I agree that Tufts Health Plan and health care providers may obtain or release my medical records and medical services-related information for the following purposes: (a) administering benefits; (b) managing care, including utilization review, quality assurance and member satisfaction procedures; (c)conducting bona fide medical research; and (d) when required by law. I understand that, except in an emergency, all health services must be provided or authorized by the Tufts Health Plan primary care physician that I have designated. I understand that calls to the Member Services Department may be monitored for quality assurance. I understand that the benefits for which I will be eligible are those described in the Tufts Medicare Complement (TMC) Evidence of Coverage.

Signature (required): _____ Date: _____

WHITE - TUFTS HEALTH PLAN COPY **PINK** - EMPLOYER COPY **YELLOW** - SUBSCRIBER COPY. Please keep yellow copy as your temporary Tufts Health Plan ID.